

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, or other arrangements, the medical examiner will be notified at once.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other significant condition contributing to death, the medical examiner will be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 6 2 6 4 0 0					
1 - FOR STATE REGISTRAR												REG. NO.			
1 DECEASED NAME (TYPE OR PRINT)		FIRST <i>MARY</i>	MIDDLE <i>L.</i>	LAST <i>Ashley</i>	2a. DATE OF DEATH		MONTH <i>9</i>	DAY <i>30</i>	YEAR <i>86</i>	2b. HOUR <i>12 45 PM</i>					
3 SEX <i>Females</i>		4 RACE <i>White</i>		5. DATE OF BIRTH MONTH <i>4</i>		DAY <i>4</i>	YEAR <i>1891</i>	6 AGE (IN YEARS LAST BIRTHDAY) 95 YRS.		IF UNDER 1 YEAR MONTHS <i>0</i>		# UNDER 24 HRS HOURS <i>12</i>			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot County</i>									
10 CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>William Hill Manor Health Care</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>									
13a STATE <i>Maryland</i>		13b COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Oxford</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>712 Morris St. 21654</i>							
14. FATHER'S NAME FIRST <i>Thomas</i>		MIDDLE <i>R.</i>	LAST <i>Lawrence</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Mary</i>		MIDDLE <i></i>	LAST <i>Wheeler</i>								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b SOCIAL SECURITY NO. <i>213-09-5674D</i>		17 INFORMANT <i>Virginia A. Medinger -Box 405-Oxford, Md.</i>		ADDRESS <i>21654</i>									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sigomie brain syndrome</i> DOUE TO, OR AS A CONSEQUENCE OF (b) <i>Simple dementia /as evs</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>26 Oct 21 1985</i>		21f. LOCATION STREET <i>322 Commerce Dr</i>		CITY OR TOWN <i>EASTON</i>	COUNTY <i>BALTO.</i>	STATE <i>Md.</i>							
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 20 1985</i> to <i>Sept 30 1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.															
22b. SIGNATURE <i>R.B. Sanchez</i>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <i>9-30-86</i>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R.B. Sanchez</i>		22e. ADDRESS <i>322 Commerce Dr EASTON MD</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>10-3-86</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Druid Ridge</i>		23d. LOCATION CITY OR TOWN <i>Pikesville</i>		COUNTY <i>Balto.</i>	STATE <i>Md.</i>						
24 FUNERAL DIRECTOR NAME <i>Ruck Towson Funeral Home, Inc.</i>		ADDRESS <i>Towson, Md. 21204</i>		25a. DATE REC'D. BY REGISTRAR <i>OCT 05 1986</i>		25b. REGISTRAR'S SIGNATURE									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in the presence of the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 1 and 2 should be detached for use in the burial permit. Then, please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 2690			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Alice R.					Bolden	September 13, 1986						11 35 AM	
3. SEX			4. RACE			5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	
Female			Black			February 12, 1912			74			IF UNDER 1 YEAR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS	
Bethel, Md.			U.S.A.			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Talbot			MONTHS DAYS HOURS MIN.	
11. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
EASTON			Memorial Hospital			Housewife			Own Home				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. STREET ADDRESS / ZIP CODE				
Maryland			Caroline			Federalsburg			319 Brooklyn Avenue				
FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
Will Ricketts						Elsie Cannon Farrington							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No			219-14-4431			Elmer B. Bolden, 319 Brooklyn Ave., Md. 21632			Federalsburg,				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Deep Wound Infection</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic decubitus ulcer</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Debilitation, ASCVD, Chronic renal failure, DM</u>													
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9/13</u> , 19 <u>86</u> , to <u>9/13</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>9/13</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22b. DATE SIGNED 9/14/86	
22b. SIGNATURE <u>MD Crowley</u>			22c. DEGREE 7th			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 9/14/86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MD Crowley			22e. ADDRESS Easton, MD										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Sept. 20, 1986			23c. NAME OF CEMETERY OR CREMATORIAL Federal Hill Cemetery			23d. LOCATION CITY OR TOWN Federalburg, COUNTY Caroline, STATE Md.				
24. FUNERAL DIRECTOR NAME Flempton-Hawkins			ADDRESS FEDERALBURG			25a. DATE REC'D. BY REGISTRAR SEP 19 1986			25b. REGISTRAR'S SIGNATURE Julia L. Johnson, R.N.				
BP _____													
DHMH - 16 60M 7/84 (VRA 15, 4)													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the Burial transit permit. Then please remove carbon paper. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8626402	
1 - STATE REGISTRAR				REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2d. DATE OF DEATH MONTH DAY YEAR				2d. HOUR		
TILLIE J						Bosley	September 16 1986				2 AM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		Negro		8- 25- 1916			70 YRS.		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH TA1bot MD.						
Maryland		USA											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
EASTON		Memorial Hospital		Easton			Laborer		Retired				
13a. STATE Md.		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge			13d. STREET ADDRESS / ZIP CODE 703 Weaver Ave. 21613						
14. FATHER'S NAME FIRST Columbus		MIDDLE -		15. MOTHER'S MAIDEN NAME FIRST Lena			16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 yrs						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT (Daughter) ADDRESS Lois S. Bosley 703 Weaver Ave. Camb., Md. 21613									
No		217-10-8760											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic breast cancer</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 yrs	
DUE TO, OR AS A CONSEQUENCE OF (b) _____													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____							
22a. I certify that (I) (this hospital) attended the deceased from <u>15 Sep 86</u> to <u>16 Sep 86</u> , that (I) (we) lost saw the deceased alive on <u>15 Sep 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 9-16-86	
22b. SIGNATURE <u>Stephen P. Carney</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M.D.			22e. ADDRESS Easton, Md. 21601										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/20/86			23c. NAME OF CEMETERY OR CREMATORIAL Bethel AME Cem.			23d. LOCATION CITY OR TOWN Cambridge, Md. COUNTY Dor., STATE Md.				
24. FUNERAL DIRECTOR NAME Boardley Funeral Home			ADDRESS 812 Hubbard St Cambridge, Md.			25a. DATE REC'D. BY REGISTRAR SEP 23 1986			25b. REGISTRAR'S SIGNATURE <u>Stephen P. Carney</u>				
DHMH - 16 60M 7/84 (VRA 15, 4)													

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be detached within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 22 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 26 903							
										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
Ethel Tarbutton Bowman						09			06	86		6:30 A.M.					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
Female		White		MONTH	DAY	YEAR	74			MONTHS	DAYS	HOURS	MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.							
Maryland		U.S.A.					Talbot										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Easton		206 Prospect Ave		Teacher			Education										
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13e. STREET ADDRESS / ZIP CODE							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		206 Prospect Ave		21601				
Maryland		Talbot		Easton		13d. INSIDE CITY LIMITS?			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		206 Prospect Ave		21601				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST	Patchett					
William			Edward		Tarbutton	Della											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
no			214-18-9116			Doran Bowman Rt 2 Box 203 Hurlock MD											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Heart failure																	
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic cardiovascular disease																	
DUE TO, OR AS A CONSEQUENCE OF and Chronic obstructive pulmonary disease																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased die on 8/13/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) not view the body after death.										219 81 to 916 86, that (I) (we) last							
22b. SIGNATURE <i>MD Crowley 7/90</i>										22c. DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			22f. DATE SIGNED			22g. DATE SIGNED								
Michael D. Crowley, M.D.			322 Commerce Drive Easton, Maryland 21601			9-8-86											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE			
Burial			9/9/86			Woodlawn Memorial Pk.			Easton			Talbot		MD			
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Newnam Funeral Home										SEP 10 1986			<i>John J. Crowley</i>				
DHMH - 16 60M 7/84 (VRA 15, 4)																	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 9 0 4

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	(LAST)	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
HORACE LEROY BRANDOW							SEPT. 14, 1986				8:45 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
MALE		CAUC.		MARCH 25, 1916			70		MONTH	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
MARYLAND		U.S.A.					TALBOT						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
WITTMAN		SEWELLS POINT RD.		WATERMAN			SEAFOOD						
13a. STATE MARYLAND		13b. COUNTY TALBOT		13c. CITY OR TOWN WITTMAN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE SEWELLS POINT RD. 21676					
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME									
		WILLIAM P. BRANDOW		ADA MAE JACKSON									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF UNKNOWN)		16b. SOCIAL SECURITY NO. -----		17. INFORMANT		ADDRESS							
NO		212-16-1269 A		SARAH A. BRANDOW		SEWELLS POINT RD. WITTMAN, MARYLAND 21676							
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC LUNG CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____													
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from saw the deceased alive on <u>9/9</u> 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (I/we) did not view the body after death.		22b. SIGNATURE <u>WB Bremer</u>		22c. DEGREE <u>MD</u>		22d. ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <u>9/16/86</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		WILLIAM S. BREMER M.D.		22e. ADDRESS 103 E. CHESTNUT ST. ST. MICHAELS, MD. 21663									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE SEPT. 17, 1986		23c. NAME OF CEMETERY OR CREMATORIAL OLIVET CEMETERY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
24. FUNERAL DIRECTOR NAME <u>Marion C. Brown</u>		ADDRESS <u>117 Michaels</u>		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>SEP 19 1986 Julie Davidson-Pender</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be
 retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3
 should be detached for use on the burial/death permit. Then please remove carbon paper. Pages 1 and 2 will be filed with the 24 hours after death
 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked at the time of any injury, an other traumatic event, the medical examiner

1528(1)

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8626905			
										REG. NO.			
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)					2. DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR	
		2-Nicholas Nikolas Lawrence Brooks					9 21 86					8:30 A.M.	
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		White		MONTH 06-02-86 DAY			YRS 3 19		MONTHS 3		DAYS 19		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8			9 BALTIMORE CITY OR COUNTY OF DEATH		MD.				
Maryland		U.S.A.		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Talbot						
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Easton		Memorial Hosp C Easton		n/a									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
Maryland		Q.A.		Stevensville		YES <input type="checkbox"/> NO <input type="checkbox"/>		28-2 William Way 21666					
14 FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		ADDRESS					
Glenn Lawrence Brooks						Kathleen Victoria Horstman							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
		n/a		Glenn L. Brooks		CARDIAC FAILURE HRS							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF CONGENITAL HEART DISEASE				3 mos					
		(c)		DUE TO, OR AS A CONSEQUENCE OF (TRANSPOSITION OF GREAT VESSELS)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		CITY OR TOWN		COUNTY		STATE	
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.													
22b SIGNATURE		22c. DATE SIGNED		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		9/21/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS											
Harold E. Bauer M.D.		Memorial Hospital, Easton, Md.											
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c NAME OF CEMETERY OR CREMATORIAL		23d LOCATION CITY OR TOWN		CITY OR TOWN		COUNTY		STATE	
Burial		09-23-86		Stevensville Cemetery		Stevensville		Stevensville		Q.A.		MD	
24 FUNERAL DIRECTOR NAME		ADDRESS		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE							
Tom Helfenbein Funeral Home, Chester, MD 21619				Oct 02 1986		J.C. Kline							

81591-09

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH A COPY OF ITEM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			ROBERT JEFFREY CLENDANIEL									2a. DATE KNOWN OF ESTI- MATED X 8 31 86			2b. MONTH DAY YEAR 31 1986						
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD Aug. 31 1986			2d. HOUR MONTH DAY YEAR 345 PM					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DELAWARE			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT			MD.											
10. CITY OR TOWN OF DEATH EASTON			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL									12a. USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE PAINTER			12b. KIND OF BUSINESS OR INDUSTRY CONST WK						
13a. STATE MARYLAND			13b. COUNTY TALBOT		13c. CITY OR TOWN EASTON		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS TALBOT VILLAGE APT 15			21601									
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT B. CLENDANIEL			15. MOTHER'S MAIDEN NAME SANDRA LEA FLEETWOOD FIGGS									16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) MA Nat'l Guard			16b. SOCIAL SECURITY NO. 222 56 3458		17. INFORMANT SANDRA L. FIGGS SEAFORD, DELAWARE			ADDRESS RD 2 BOX 21 L	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8161 IMMEDIATE CAUSE (a) Base / Scull Fracture DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Auto accident DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:00 AM 8 31 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Car went off road - Passenger		21d. PLACE OF INJURY (AT HOME, OFFICE, FACTORY, FARM, ETC.) None		21e. LOCATION STREET Cordova, RT 309 TALBOT Co. MD		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE R. Deuel Watson			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/>		and in my opinion			M.D. R. Deuel Watson , MEDICAL EXAMINER			DATE SIGNED 8-31-86										
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE SEPT 3, 1986		23c. NAME OF CEMETERY OR CREMATORIUM O'Dell's CEMETERY SEAFO RD		23d. LOCATION CITY OR TOWN SEAFO RD SUSSEx DELAWARE		25a. DATE REC'D. BY REGISTRAR SEP 04 1986			25b. REGISTRAR'S SIGNATURE Julia Johnson-Rudner									
24. FUNERAL DIRECTOR NAME PAYNTER M. WATSON - SEAFO RD, DELAWARE			ADDRESS																		
DHMH - 17 (VR A15 ME (5))																					

05001-00

Item14 1-17-90

FOR
STATE
REGISTRAR Raymond COLESTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

86 26901

0-18368

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be used with 72 hours after death.

IMPORTANT: If item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT) Raymond Cole				2a. DATE OF DEATH MONTH DAY YEAR September 12 1986	2b. MONTH SEP	2c. DAY 12	2d. YEAR 1986	2e. HOUR 12 PM		
1. SEX Male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR March 11, 1897	6. AGE (IN YEARS LAST BIRTHDAY) 89	7a. IF UNDER 1 YEAR MONTH DAY 00 00 00	7b. IF UNDER 24 HRS HOURS MIN. 00 00					
7a. BIRTHPLACE COUNTRY Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Talbot						
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT HOSPITAL FACILITY, GIVE STREET ADDRESS) Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Insurance Office Manager		12b. KIND OF BUSINESS OR INDUSTRY MD			
13a. STATE Maryland	13b. COUNTY Kent	13c. CITY OR TOWN Chestertown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Maple Ave 21914						
14. M Robert C. Charles Cole		15. MOTHER'S MAIDEN NAME Martha Ellen (Unknown)								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. 232 05 1630	17. INFORMANT Raymond C. Cole, Jr. Rock Hall, Md. 21661	ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for part I, II, and III) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last			Cerebrovascular Accident			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48s				
(b) DUE TO, OR AS A CONSEQUENCE OF Arteriosclerosis										
(c) DUE TO, OR AS A CONSEQUENCE OF										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Previous CVA										
19a. DATE OF OPERATION 9/4/86	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Constrict Heart Block (Pacemaker insertion)			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7 AM, September 12 1986	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) fall down								
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT HOME <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) at home	21f. LOCATION STREET 920	CITY OR TOWN Chestertown	COUNTY Talbot	STATE MD					
22a. I certify that (I this hospital) attended the deceased from 9/11 1986 to 9/12 1986 , that (I was last seen the deceased alive on 9/11 1986 and that in my opinion death occurred on the date and hour and from the causes stated above, (I was (not) able to view the body after death.)									22b. DATE SIGNED 9-12-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Scott D. Friedman MD		22e. DEGREE MD	22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22g. DATE SIGNED 9-12-86						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/15/86	23c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery	23d. LOCATION CITY OR TOWN Chestertown, Md.	23e. COUNTY Talbot	23f. STATE MD					
24. FUNERAL DIRECTOR NAME Willis Wells	25a. DATE REC'D. BY REGISTRAR SEP 19 1986	25b. REGISTRAR'S SIGNATURE John Wilson-Wells								

80001-00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked "X" shows any injury, or other traumatic event, the medical examiner will be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 6 2 6 4 0 8			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR						
Veronica C. Collins						Sept. 13, 1986			1:00 AM						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS			2b. HOUR IF UNDER 24 HRS. HOURS MIN.					
FEMALE		CAUCASIAN		MAR 6, 1906			80 YRS								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Talbot								
NEW JERSEY		U.S.													
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY 99999								
13a. STATE NEW JERSEY		13b. COUNTY HUDSON		13c. CITY OR TOWN JERSEY CITY			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 135 MONTGOMERY ST / 07302						
14. FATHER'S NAME FIRST MIDDLE LAST JOHN CLARKE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA NORTON													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 153-16-6521			17. INFORMANT JEREMIAH COLLINS			ADDRESS 6 HILL ROAD DENVILLE, N.J. 07834							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Mesoblastic Carcinoma of Lung</i>												APPROXIMATE NUMBER OF DAYS BETWEEN ONSET AND DEATH 1 mo			
DUE TO, OR AS A CONSEQUENCE OF (b) _____															
DUE TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____										
22a. I certify that (I) (this hospital) attended the deceased from <i>9/12</i> , 1986, to <i>9/13</i> , 1986, that (I) (we) last saw the deceased alive on <i>9/12</i> , 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.												22c. DATE SIGNED <i>9/13/86</i>			
22b. SIGNATURE <i>Warren Woods</i>		DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Wm H Woods Jr</i>		22e. ADDRESS <i>EASTON, MD.</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9-19-1986		23c. NAME OF CEMETERY OR CREMATORIAL CALVARY CEMETERY			23d. LOCATION CITY OR TOWN _____ COUNTY _____ STATE _____			QUEENS, QUEENS CO., NEW YORK					
24. FUNERAL DIRECTOR NAME NEWNAM FUNERAL HOME		ADDRESS EASTON, MD.			25a. DATE REC'D. BY REGISTRAR SEP 17 1986			25b. REGISTRAR'S SIGNATURE <i>Ward Newnam</i>							
BP												DHMH - 16 60M 7/84 (VRA 15, 4)			

00-18301



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 through 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8626409
1 - FOR STATE REGISTRAR				REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
		ANTOINETTE HARRISON COVINGTON			AUGUST 27, 1986					8:15 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
FEMALE		CAUC.		JULY 21, 1909		77		YEARS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT		MD.				
10. CITY OR TOWN OF DEATH TILGHMAN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHICKEN PT. RD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SCHOOL PRIN.		12b. KIND OF BUSINESS OR INDUSTRY EDUCATION						
13a. STATE MARYLAND		13b. COUNTY TALBOT		13c. CITY OR TOWN TILGHMAN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS CHICKEN PT. RD. 21671				
14. FATHER'S NAME FIRST IRA B. HARRISON		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST ELSIE BRUMELL		MIDDLE				LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. -----		17. INFORMANT HARRY R. COVINGTON		ADDRESS 9014 S. U.S. HIGHWAY 285 MORRISON, COLOR. 80465				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) An SCVD & hypertension												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Alzheimers Disease												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 821		21f. LOCATION STREET CITY OR TOWN 821		CITY OR TOWN 821		COUNTY 86		STATE 00		
22a. I certify that (I) this hospital attended the deceased from 8/21 , 19 75 , to 8/21 , 19 86 , that (I) we last saw the deceased alive on 8/21 , 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated and that in my (our) opinion death occurred on the date and hour and from the causes stated												
22b. SIGNATURE Albert T. Dawkins		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 8-28-86								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALBERT T. DAWKINS JR. M.D.		22e. ADDRESS Route 3, Box 127 DUTCHMANS LANE EASTON, MARYLAND 21601										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG. 30, 1986		23c. NAME OF CEMETERY OR CREMATORIAL TILGHMAN MEMORIAL CEM. TILGHMAN		23d. LOCATION CITY OR TOWN TALBOT		COUNTY MARYLAND		STATE		
24. FUNERAL DIRECTOR NAME Harrison E. Leonard, Jr., Michael, M.D.		ADDRESS SEP 08 1986		25a. DATE REC'D. BY REGISTRAR SEP 08 1986		25b. REGISTRAR'S SIGNATURE JULY 1986						

10001-01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked "Q" item 28 shows any injury, or other traumatic or violent cause of death.

MEDICAL CERTIFICATION

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 26 910

REG. NO.

I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
<i>William</i>			<i>Herbert</i>	<i>Dail</i>		<i>9/12/86</i>				<i>1205 PM</i>			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 21 YEARS			
<i>Male</i>		<i>WHITE</i>		MONTH <i>5</i>	DAY <i>15</i>	YEAR <i>18</i>	68	YEARS	MONTHS	MONTHS	HOURS		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
<i>Maryland</i>		<i>U.S.A.</i>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<i>TALBOT</i>							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
<i>Easton</i>		<i>Memorial Hospital</i>		<i>Postal Clerk</i>		<i>Postal Dept.</i>		<i>21613</i> (Hudson)					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
<i>Maryland</i>		<i>Dorchester</i>		<i>Cambridge</i>		YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	<i>Rt. 3, Box 340</i>					
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		ADDRESS					
<i>William</i>		<i>S.</i>		<i>Dail</i>		<i>M.</i>		<i>Elsie</i>		<i>Rumbley</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF UNKNOWN) WW II		16b. SOCIAL SECURITY NO. WW II		17. INFORMANT		18. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR 1a, 1b, AND 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
		<i>220-26-4074</i>		<i>Mrs. L. Dail, same as #13</i>		<i>Bladder CANCER</i>		<i>2 yrs</i>					
18. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause first		(b)		19. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (c)		20. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.							
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED		21c. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)									
21g. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21h. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21i. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>JULY 19 85</i> to <i>12 580</i> , 1986, that (I) (we) last saw the deceased alive on <i>12 580</i> , 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.													
22b. SIGNATURE <i>Stephen P. Carney, M.D.</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>9-12-86</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN			
<i>Stephen P. Carney, M.D.</i>		<i>Easton, Md. 21601</i>		<i>Burial</i>		<i>9-15-86</i>		<i>Dorchester Cemetery</i>		<i>Cambridge, Dorchester, Md.</i>			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
<i>Curran Funeral Home</i>		<i>Cambridge, Md. 21613</i>		<i>SEP 22 1986</i>									

BP _____

35181-00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the Hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/transit parlor. Then please remove carbon paper. Page 1 & 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 22 is marked on this certificate, the medical examiner will be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										862691							
										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
LLOYD MARTIN ERICKSON						September 13, 1986			SEPTEMBER	13	1986	11 47 AM					
2. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.			
Male			Cau			July 9, 1913			73 YRS								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED X NEVER MARRIED DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH			MD					
New York			USA						Talbot County								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
St. Michaels			Rt #1, Box 159, Ray's Point Rd.										Self-employed			Real Estate	
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			21663		
Maryland			Talbot			St. Michaels						Ray's Point Rd., St. Michaels					
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST		
Martin Thomas Erickson									Olga Jacobsen								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon</u>			St. Michaels, MD		
Yes			WW II			065-10-7814			Marjorie T. Erickson			Ray's Point Rd.,					
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon</u>			DUE TO, OR AS A CONSEQUENCE OF (b) _____			DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 19 86</u> to <u>Aug 19 86</u> , and that (I) (we) lost saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.																	
22b. SIGNATURE <u>JAMES C. Gieske</u>			22c. DEGREE <u>MD</u>						ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>Sept 15, 1986</u>					
22d. PHYSICIAN'S NAME: (TYPE OR PRINT) JAMES C. Gieske, M. D.			22e. ADDRESS 505 Dutchman's Lane, Easton, Maryland														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Sept 15, 1986			23c. NAME OF CEMETERY OR CREMATORIAL Lee Crematory			23d. LOCATION CITY OR TOWN Washington, D. C.			23e. COUNTY D. C.			STATE		
24. FUNERAL DIRECTOR NAME Sharon E. Leonard, St. Michaels, Md.			ADDRESS			25. DATE REC'D. BY REGISTRAR SEP 19 1986			25. REGISTRAR'S SIGNATURE J. Gieske, M.D.								
DHMH - 16 60M 7-B4 (VRA 15, 4)																	

00-1988



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be signed by the funeral director, page 3 should be detached from the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, air other traumatic event, the medical examination must be completed.

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 9 1 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST Jerome	MIDDLE George	LAST Gebhardt	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
<i>Jerome Gebhardt</i>				9-2-86				8 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Male		White		MONTH	DAY	YEAR	76	YRS	MONTHS	DAYS	IF UNDER 24 HRS
12-26-09											
7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH				MD.	
Maryland		U.S.A.				Talbot					
11. CITY OR TOWN OF DEATH		memorial Hospital Easton				12a. USUAL OCCUPATION				12b. KIND OF BUSINESS OR INDUSTRY	
EASTON						(TYPE OF WORK FOR MOST OF WORKING LIFE)				Industrial Engineer	
13. USUAL RESIDENCE IF IN NURSING HOME OR OTHER INSTITUTION. GIVE RESIDENCE BEFORE ADMISSION		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland		Q.A.		Queenstown		YES <input type="checkbox"/> NO <input type="checkbox"/>		Rt. 1 Box 168		21658	
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST		
George Gebhardt					Anna Buschman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.				17. INFORMANT		ADDRESS			
No		215-10-2121				Olga L. Gebhardt		same as above			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ruptured Ventricular Septum</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial Infarction</i> Days											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary Artery Disease</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR		P.M.							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>											
22a. I certify that (I) (we) attended the deceased from		8/30		86		19		9/2		86	
saw the deceased alive on		9/2		86		19		9/2		86	
above (I) (we) did not view the body after death											
22b. SIGNATURE						DEGREE		22c. DATE SIGNED			
<i>Scott D. Friedman MD</i>								11/2/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Scott D. Friedman		403 Massey Cr Easton MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		09-05-86		Lorraine Park Cemetery		Baltimore		Balt.		MD.	
24. FUNERAL DIRECTOR NAME		ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE	
Tom Helfenbein Funeral Home, Chester, MD 21619						SEP 15 1986					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and countersigned by the funeral director, page 3 should be detached to use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked **Yes**, Item 18 shows any injury, or other traumatic event, the medical examiner has the authority to make an examination.

MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRAR:STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 26 4 1 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	26 HOUR	
Roy				Ellis	Golt	09/03/86				8.50 AM	
3. SEX		4. RACE	5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male		White	MONTH	DAY	YEAR	91	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						
Maryland		U.S.A.			9 BALTIMORE CITY OR COUNTY OF DEATH Talbot County MD.						
III. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer						
Easton		William Hill Manor			12b. KIND OF BUSINESS OR INDUSTRY						
USUAL RESIDENCE IF HAVING HOME OR OTHER INSTITUTION. GIVE RESIDENCE BEFORE ADMISSION					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>						
11a. STATE Maryland		11b. COUNTY Q.A.		11c. CITY OR TOWN Chester	13e. STREET ADDRESS / ZIP CODE Rt. 1 Box 283 21619						
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Annie Johnson			MIDDLE			LAST	
Elmer Golt											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. NO 217-42-5857			17. INFORMANT Marie A. Golt			ADDRESS same as above			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable myocardial infarction</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <u>Aortic insufficiency</u>						Years			
		(c) <u>Artherosclerotic cardiovascular disease</u>						Years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/2 1986 to 9/3 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we did/did not) view the body after death.											
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/3/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ludwig J. Eglseider III MD		22e. ADDRESS RT 3 Box 106 Dutchman Lane EASTON MD 21601									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 09-06-86	23c. NAME OF CEMETERY OR CREMATORIAL Stevensville Cemetery			23d. LOCATION CITY OR TOWN Stevensville COUNTY Q.A. STATE MD					
24. FUNERAL DIRECTOR NAME Tom Helfenbein Funeral Home, Chester, MD 21619		25a. DATE REC'D. BY REGISTRAR Sep 10 1986			25b. REGISTRAR'S SIGNATURE						

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00-18504

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain spaces (1, 2, 3, 4, 5, 6, 7 and 9) and re-fold the card within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 1B shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8026114			
										REG. NO.			
1. FOR STATE REGISTRAR DEBORAH A. GWYN			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			9 15 86			1:50 PM				
Deborah A Gwyn													
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR 4-20-1904			6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE CITY			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH JACOBOT CO. MD.				
10. CITY OR TOWN OF DEATH EASTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WILLIAM H. K. MARBLE			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY -				
13a. STATE MD.			13b. COUNTY RENT CHESTERFIELD			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE QUEEN ST. 21620				
14. FATHER'S NAME FIRST MIDDLE LAST JOHN PAUL TINBLE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DEBORAH ANN BARIES			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) -			16b. SOCIAL SECURITY NO. 215-05-0557				
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)			17. INFORMANT JOHN HINRICH COOK			ADDRESS ST. MCGAHEES MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause first. (c)			19. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 814			21f. LOCATION STREET Dutchman's Lane			CITY OR TOWN RT 3 Box 106 EASTON MD 21601				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from saw the deceased alive on 9/8/86 , and that <input type="checkbox"/> (I) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We did) <input type="checkbox"/> did not view the body after death.			22b. SIGNATURE Ludwig J. Eglseder III MD			22c. DEGREE MD			22d. DATE SIGNED 9/15/86				
22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF Ludwig J. Eglseder III MD			22f. ADDRESS Silverbrook Cemetery			23d. LOCATION CITY OR TOWN Wilmington, Del.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 9/16/86			23c. NAME OF CEMETERY OR CREMATORIAL I. Willis Wells			23d. LOCATION CITY OR TOWN Chestertown, Md.				
24. FUNERAL DIRECTOR NAME I. Willis Wells						25a. DATE REC'D. BY REGISTRAR SEP 19 1986			25b. REGISTRAR'S SIGNATURE DEBORAH A. GWYN				

10201-00

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 6 2 6 4 1 5		
												REG. NO.		
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR		
<u>PERCIVAL</u>					<u>HALLOWELL</u>	<u>SEPT 24 1986</u>						<u>7:08 A</u>		
1. SEX		4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Male		White			MONTH	DAY	YEAR	90			MONTHS	DAYS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?			8.			10. CITY OR TOWN OF DEATH			9. BALTIMORE CITY OR COUNTY OF DEATH			
<u>Pennsylvania</u>		<u>U.S.A.</u>			MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	<u>EASTON</u>			<u>TALBOT</u>		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (DO NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13a. STREET ADDRESS / ZIP CODE					
<u>EASTON MEMORIAL Hospital</u>			<u>Bond trader</u>			<u>Financial</u>			<u>Rt 4 Box 498</u>			<u>21601</u>		
13c. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE					
<u>Maryland</u>		<u>Talbot</u>		<u>Easton</u>		YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	<u>Rt 4 Box 498</u>			<u>21601</u>			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST	16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<u>Horace</u>			<u>Gates</u>	<u>Jones</u>	<u>Hallowell</u>			<u>Anne</u>		<u>O'Brien</u>	<u>16 mo</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
Yes <u>WWI</u>			<u>067-03-0165</u>			<u>Charles E Wheeler P O Box 1209 Easton MD 21601</u>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PROSTATE CANCER</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>16 mo</u>		
DUE TO, OR AS A CONSEQUENCE OF (b) _____														
DUE TO, OR AS A CONSEQUENCE OF (c) _____														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____								
22a. I certify that (I) (this hospital) attended the deceased from <u>6</u> , 19 <u>73</u> , to <u>9-24</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>9-23</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>Stephen P. Carney, M.D.</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>9-24-86</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Stephen P. Carney, M.D.</u>			22e. ADDRESS <u>Dutchman's Lane Easton MD 21601</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <u>9/25/86</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>Salisbury Crematory</u>			23d. LOCATION CITY OR TOWN _____ COUNTY _____ STATE _____					
Cremation														
24. FUNERAL DIRECTOR NAME <u>Newnam Funeral Home</u>			ADDRESS <u>Easton MD 21601</u>			25a. DATE REC'D. BY REGISTRAR <u>SEP 29 1986</u>			25b. REGISTRAR'S SIGNATURE <u>J. Newnam</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Retained by the Hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit. Then please remove carbon copy pages 1 and 2, that should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 (harmless injury, or other traumatic event, the medical examiner must be notified).

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.									
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR									
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR						
George Tennyson Hardin						09 18 86							8:00 P M						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.						
Male		White		11 08 07			78 YRS												
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland		U.S.A.						Talbot											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY							
Easton		308 Brookletts Ave				Owner/Operator						Variety Store							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS / ZIP CODE				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS / ZIP CODE								
Maryland		Talbot		Easton							308 Brookletts Ave 21601								
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		ADDRESS								
George		Tennyson		Hardin Sr	Hattie						Payne								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. WW II			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
			213-01-8162			Shirley T. Smith Rt 3 Box 230 Easton MD			Immediate 4 1/2 yrs										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										Fatal arrhythmia									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										DUE TO, OR AS A CONSEQUENCE OF (b) <i>As N.D.</i>									
										DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)													
21d. INJURY OCCURRED <i>WHILE AT WORK</i> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>5-10</i> , 19 <i>84</i> , to <i>9-18</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>8-29</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																			
22b. SIGNATURE <i>Stephen P. Carney</i>										DEGREE									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
Stephen P. Carney, M.D.										22e. ADDRESS Dutchman's Lane Easton MD 21601									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 9/22/86			23c. NAME OF CEMETERY OR CREMATORIAL MD. Veteran's Cemetery			23d. LOCATION Hurlock		CITY OR TOWN		COUNTY		STATE				
Burial													Dorchester		MD				
24. FUNERAL DIRECTOR NAME Newnam Funeral Home										25a. DATE REC'D. BY REGISTRAR SEP 23 1986						25b. REGISTRAR'S SIGNATURE			
ADDRESS Easton MD																			

00198100

2000 COLORADO



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reprinted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 will be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal of the body.

IMPORTANT: If item 21 is marked "Yes", Item 18 should state any injury, or other traumatic event.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						86 26917		
						REG. NO.		
1. FOR STATE REGISTRAR	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
1 DECEASED NAME (TYPE OR PRINT)	Clara	Leigh	Hill	9	7	86		6 ⁰ M
3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	IF UNDER 24 HRS			
Female	Caucasian	Month Day Year May 28, 1888	98	MONTHS DAYS	HOURS MIN.			
7a. BIRTHPLACE (COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
New Jersey	U.S.A.		Talbot County					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY			
Easton	EASTON MEMORIAL			Housewife	Home			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE				
Maryland	Caroline	Denton		MD Route 317	21629			
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST			
Paul Tulane Livingston	Leigh		Sarah Margaret		Drake			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT Blanche H. Voorhees, Denton, MD	ADDRESS					
No	139389283							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Pneumonia								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from Sept 7, 1986, to Sept 7, 1986, that (I) (we) last saw the deceased alive on Sept 7, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) did (did not) view the body after death.								
22b. SIGNATURE <i>Rob Lappin</i>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 9/8/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rob Lappin	22e. ADDRESS CHS PO Box 172 Goldsboro Md 21636							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE 9/11/86	23c. NAME OF CEMETERY OR CREMATORIAL Highland Cemetery	23d. LOCATION CITY OR TOWN Hopewell Mercer N.J.	STATE				
24. FUNERAL DIRECTOR NAME Moore Pineback House Devon, MD.	ADDRESS	25a. DATE REC'D. BY REGISTRAR SEP 17 1986	25b. REGISTRAR'S SIGNATURE Julia Sander-Lindner					
DHMH - 16 60M 7/84 (VRA 15, 4)								

10201-00

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00-20009

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 4 1 8

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME Ruby Mae Howard			2a. DATE OF DEATH 9-29-86	MONTH 9	DAY 29	YEAR 86	2b. HOUR 7:25 PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH 07 23 97	6. AGE IN YEARS LAST BIRTHDAY 89 yrs.	7. IF UNDER 1 YEAR MONTHS	8. IF UNDER 2 YEARS DAYS	9. IF UNDER 5 YEARS HOURS	10. IF UNDER 1 MONTH MINUTES	
11. BIRTHPLACE COUNTRY Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Talbot					
14. CITY OR TOWN OF DEATH Easton	15. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Memorial Hospital	16. USUAL OCCUPATION Housewife	12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland	13b. COUNTY Caroline	13c. CITY OR TOWN Marydel	13d. INSIDE CITY LIMITS? NO	13e. STREET ADDRESS / ZIP CODE Rt 1 Box 118 21649				
14. FATHER'S NAME James Cary Mercer	15. MOTHER'S MAIDEN NAME Inez Daniel	16. ADDRESS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO	16b. SOCIAL SECURITY NO. 215-12-7584	17. INFORMANT Earl Howard Rt 1 Box 118 Marydel MD 21649						
18. CAUSE OF DEATH (Enter only one cause per line for item 18, and) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocard Infarct. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours								
DUE TO, OR AS A CONSEQUENCE OF (b) ASHD - & Coronary Art. Occlif. Yrs								
DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis Yrs								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b Atherosclerosis of bowel								
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? NO	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? NO				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR: A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b PART 1 OR PART 2) sovereign						
22a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	22c. LOCATION STREET	CITY OR TOWN	COUNTY	STATE			
22d. I certify that (i) this hospital attended the deceased from Sept 29 1986 to Sept 29 1986 that (ii) (we) saw the deceased alive on Sept 29 1986 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, check here.)								
22e. SIGNATURE Richard F. Manegold, M.D.								
22f. DEGREE MD								
22g. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22h. DATE SIGNED 4/30/86								
22i. PHYSICIAN'S NAME (TYPE OR PRINT) Richard F. Manegold, M.D.								
22j. ADDRESS 115 Bay St Easton MD 21601								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/2/86	23c. NAME OF CEMETERY OR CREMATORIAL Harmony Grove Bap. Cem.	23d. LOCATION CITY OR TOWN Topping	COUNTY	STATE			
24. FUNERAL DIRECTOR Peter J. Newnam	25a. ADDRESS Easton MD	25b. DATE REC'D. BY REGISTRAR OCT 06 1986	25b. REGISTRAR'S SIGNATURE Davidson-Pandell					
DHMH - 16 60M 7/84 (VRA 15, 4)								

900CS-00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 0 2 6 4 1 9		
												REG. NO.		
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			Pauline N. Ireland						September 28, 1986 2pm					
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 24 HRS.		
Female			White			10 18 29			56 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Maryland			U.S.A.						Talbot					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN STATE/CITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Easton			Memorial						licensed prac. nurse			Medical		
13. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
Maryland			Talbot			Easton			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			409 Winton Avenue 21601		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
Roland W. Morgan Sr.			Marjorie			220-26-7784			Frederic E. Ireland			409 Winton Ave Easton MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Cancer to bone and liver</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of Left Breast</i>												8 yrs		
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>9/27/86</i> to <i>9/28/86</i> , that (I) (we) last saw the deceased alive on <i>9/27/86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.														
22b. SIGNATURE <i>Wm H. Wood Jr.</i>			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 9/28/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Wm H. Wood Jr.</i>			22e. ADDRESS EASTON, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/30/86			23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery			23d. LOCATION CITY OR TOWN Easton			COUNTY STATE Talbot MD		
24. FUNERAL DIRECTOR NAME Newnam Funeral Home			ADDRESS Easton, MD. 21601			25a. DATE REC'D. BY REGISTRAR OCT 01 1986			25b. REGISTRAR'S SIGNATURE <i>John Newnam</i>					

DO-13923

CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The

—in 24 hours either death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 4 and 5 would be filled within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 2 6 9 2 0			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
<i>George Anna Jester</i>					<i>Jester</i>	9 3 86				50 PM			
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
<input checked="" type="checkbox"/> Female			Caucasian		April 30, 1902	84 YRS							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				MD.			
<i>Maryland</i>			<i>U.S.A.</i>			<i>Talbot County</i>							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY				
<i>Easton</i>			<i>EASTON MEMORIAL</i>		<i>Housewife</i>				<i>Home</i>				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		21629			
<i>Maryland</i>		<i>Caroline</i>		<i>Denton</i>				<i>Denton-Greensboro Road</i>					
FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
<i>Charles Edward Hutson</i>			<i>Carline Bright</i>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (ES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.										
No			212161884										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<i>Car dyspulmonary Arrest</i>													
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerotic Cardiovascular Disease</i>										years			
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>AUG. 1 - 19 85</i> , to <i>SEPT 3 19 86</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>SEPT. 3 19 86</i> , and that in <input checked="" type="checkbox"/> (my) our opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I/we) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> (did not) view the body after death.													
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
<i>Mary Campagnolo MD</i>										<i>9-4-86</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS										
<i>MARY CAMPAGNOLO, MD</i>			<i>P.O. Box 660 Denton Md 21629</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial			9/7/86		Denton Cemetery			Denton		Caroline		Md	
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
<i>Nozzer Funeral Home Denton Md</i>						<i>SEP 08 1986</i>							

S 4081-3

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 9 2

1 - STATE
REGISTRAR

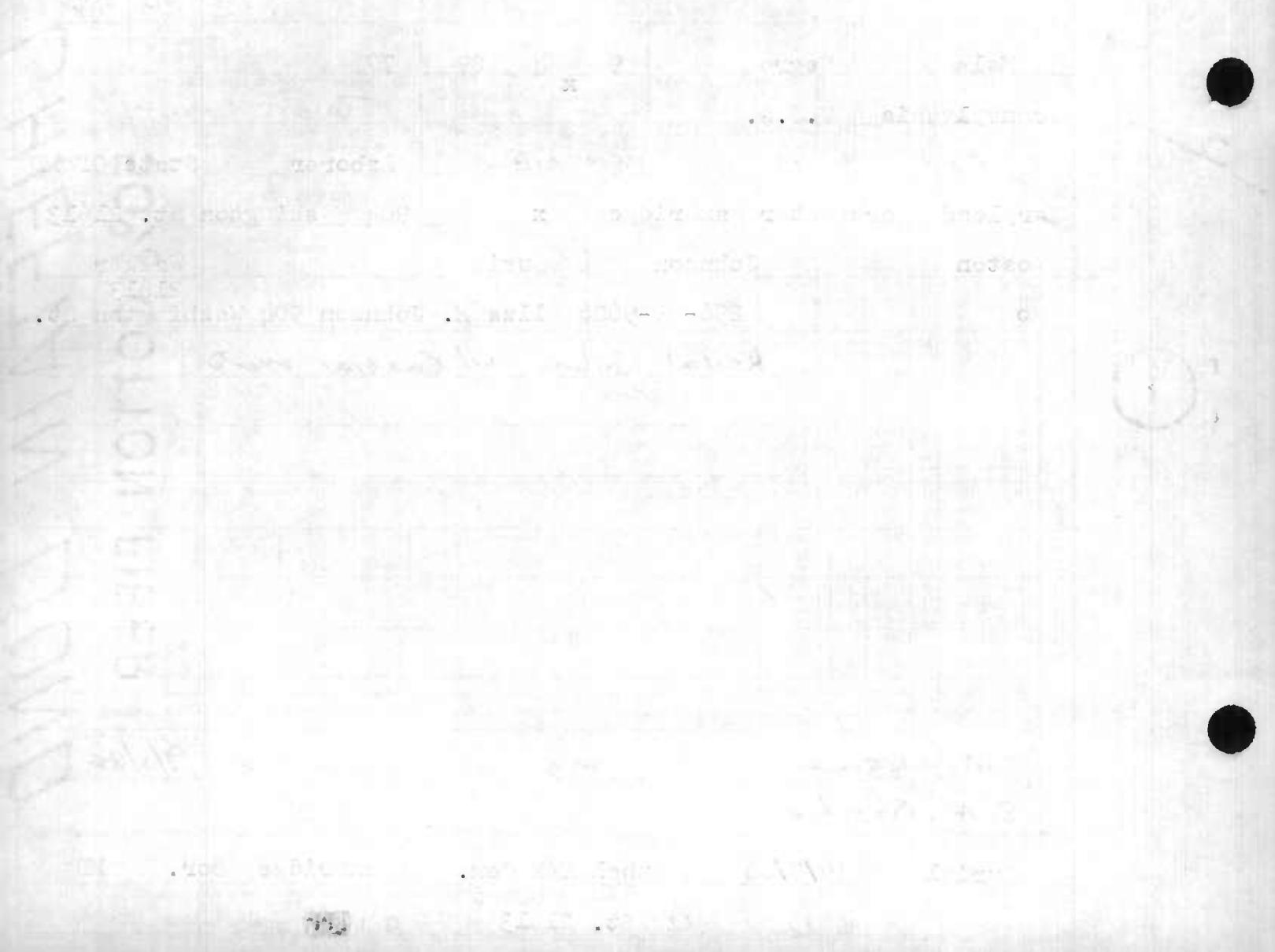
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>James</i>	MIDDLE 	LAST <i>Johnson</i>	26. DATE OF DEATH MONTH DAY YEAR <i>9 3 86</i>	MONTH <i>9</i>	DAY <i>3</i>	YEAR <i>86</i>	26. HOUR 4 ¹⁵ P M	
3. SEX <i>Male</i>	4. RACE <i>Negro</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>9 14 09</i>	6. AGE (IN YEARS LAST BIRTHDAY) 77 yrs			7. UNDER 1 YEAR MONTHS DAYS			8. UNDER 24 MONTHS MONTHS DAYS	9. HOUR HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>EASTON MEMORIAL</i>		12a. BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot County</i>		
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. CITY OR TOWN <i>Dorchester Cambridge</i>		13d. STREET ADDRESS / ZIP CODE <i>90½ Washington St. 21613</i>		17b. KIND OF BUSINESS OR INDUSTRY <i>Laborer State Of MD</i>		
14. FATHER'S NAME MIDDLE <i>Boston</i>	15. MOTHER'S MAIDEN NAME MIDDLE <i>Susie</i>									LAST <i>Walker</i>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF NO OR UNKNOWN) <input type="checkbox"/> YES <input checked="" type="checkbox"/> GIVE WAR OR DATES <i>No</i>	16b. SOCIAL SECURITY NO. <i>256-09-9626</i>	17. INFORMANT <i>Eliza E. Johnson</i>		17e. ADDRESS <i>90½ Washington St.</i>						18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c)											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (i) <i>Renal failure w/ Cardiac arrest</i>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause first											
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
(c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(i)											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE				
22a. I certify that (i) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (ii) (we last saw the deceased alive on _____ 19 _____) and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (iii) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>S. M. Bysshe</i>		DEGREE <i>ms</i>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <i>9/3/86</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>S. M. Bysshe</i>		22e. ADDRESS <i>Cambridge, Md</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>9/7/86</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Bethel AME Cem.</i>		23d. LOCATION CITY OR TOWN <i>Cambridge Dor.</i>		STATE <i>MD</i>				
24. FUNERAL DIRECTOR NAME <i>Lewis H. Boardley</i>		ADDRESS <i>812 Hubbard St. 21613</i>	25a. DATE REC'D. BY REGISTRAR <i>SFP 9-18</i>		25b. REGISTRAR'S SIGNATURE <i>J. W. BURKE</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be informed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician, then phone name and address with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or either funeral director or attending physician has been notified, then phone name and address with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

0-12384



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.											
1 - STATE REGISTRAR			2a DATE KNOWN OF ESTI. DEATH MATED									2b HOUR											
1 DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			MONTH	DAY	YEAR	2b HOUR								
Willard			NORMAN			Lane						X	5	15	1986	13 10							
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. DATE REC'D. BY REGISTRAR			2b HOUR			
Male		Cauca.		Dec 13, 1927			58 yrs.			MONTHS		DAYS		HOURS		MIN		Sept 15 1986			12 10		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH											
Maryland			U.S.A.									TA160t											
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY								
EASTON			Memorial Hospital									Repairman			Telephone								
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												21629											
13a STATE		13b COUNTY		13c CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS													
Maryland		Caroline		Denton						224 South Second St.													
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME																	
Willard E. Lane						Myrtle																	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (INCLUDE ACTIVE DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS														
Yes WW II			215200591			Wanda Lane, Denton, Maryland			21629														
18. CAUSE OF DEATH (Enter only one cause per line for parts (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20. AUTOPSY?											
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE						TITLE SPECIFY			M.D.			MEDICAL EXAMINER			DATE SIGNED								
EXAMINER'S NAME (TYPE OR PRINT)			R. Lane Wroth, M.D.			ADDRESS			St. Michaels, MD 21663						9-15-86								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY			STATE								
Burial			9/17/86			Denton Cemetery			Denton			Caroline			MD								
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE														
Moore Funeral Home Denton						SEP 19 1986			Julie Davidson Parker														

00031-00

7

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and returned to you, it may be filed in the funeral director's page 3. This page 3 should be filed within 72 hours after death.

MEDICAL CERTIFICATION

1 -
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 9 2 3

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Willett B					Laster	9 / 7 / 1986				2:10 P
1. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		
<i>Female</i>	<i>BLK</i>	MONTH	DAY	YEAR	<i>86</i>	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
8a. STATE	13b. COUNTY	13c. CITY OR TOWN				<i>Talbot</i>				
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					
<i>Easton</i>					<i>Meridian - The Pines</i>					
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <i>MD</i> 13b. COUNTY <i>Talbot</i> 13c. CITY OR TOWN <i>St Michael</i>					<i>Domestic</i>					
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME	FIRST	MIDDLE	LAST	
<i>Joe</i>			<i>b</i>		<i>white</i>	<i>Eva</i>			<i>Fences</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT	ADDRESS			
<i>NO</i>			<i>231-16 0508</i>			<i>Edith</i>	<i>Postle</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</i>										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
DUE TO, OR AS A CONSEQUENCE OF (b) _____										
DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>9/15/86</i> to <i>9/5/86</i> , that (I) (we) lost saw the deceased alive on <i>9/15/86</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>WBrenner</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN	<input type="checkbox"/> MEDICAL DIRECTOR	<input type="checkbox"/> STAFF PHYSICIAN	22c. DATE SIGNED <i>9/15/86</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Wm S BREMER MD</i>		22e. ADDRESS <i>ST. MICHAELS MD 21663</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>9/15/86</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Thomas Com.</i>		23d. LOCATION CITY OR TOWN <i>St Michaels</i>		COUNTY	STATE	
24. FUNERAL DIRECTOR NAME <i>Stewart P. H. — G.H. Postle</i>		ADDRESS		25a. DATE REC'D. BY REGISTRAR <i>SEP 15 1986</i>		25b. REGISTRAR'S SIGNATURE <i>Wade</i>				

33851-00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

00-20005

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 9 2 4

REG. NO.

1. DECEASED NAME			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
			Pauline	Lewis		9/19/86				12:15 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
female		white		MONTH DAY YEAR Sept. 5, 1902		84		MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
Maryland		USA				Talbot						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Easton		Meridian - The Pines - Easton		Housewife								
13a. STATE		NB. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		RFD Pomona 21620			
Maryland		Kent	Chestertown									
FATHER'S NAME		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME								
FIRST				FIRST		MIDDLE		LAST				
August Santos												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
no		198 05 5248		Harold Kennedy		Chestertown, Md. 21620		10 HRS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u>												
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>End stage renal disease secondary to nephrosclerosis</u>												
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated												
22b. SIGNATURE <u>Lawrence D. Bohan</u>												
22c. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 9/20/86						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation												
23b. DATE 9/24/86		23c. NAME OF CEMETERY OR CREMATORIAL Silverbrook Crematory		23d. LOCATION CITY OR TOWN Wilmington, Del.		COUNTY				STATE		
24. FUNERAL DIRECTOR NAME J. Willis Wells		ADDRESS Chestertown, Md. 21620		25a. DATE REC'D. BY REGISTRAR OCT 03 1986		25b. REGISTRAR'S SIGNATURE <u>J. Willis Wells</u>						

2008S-00



ROSS CREEK
WATER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be surrendered to you within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 26425						
										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
William E					Loller	September 19 1986			5 PM			5 PM				
3. SEX			4. RACE		5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)					
Male			white		Sept 24, 1912						73	YRS	IF UNDER 1 YEAR MONTHS DAYS			
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED			NEVER MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS HOURS MIN.		
Maryland			USA		<input checked="" type="checkbox"/>			<input type="checkbox"/>			Talbot					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
EASTON			Memorial Hospital			Truck Driver - Beer Distrib.										
13a. STATE Maryland			13b. COUNTY Kent		13c. CITY OR TOWN Worton		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e. STREET ADDRESS / ZIP CODE Rte Box # 40						
14. FATHER'S NAME FIRST			MIDDLE		LAST		15. MOTHER'S MAIDEN NAME Bertha Skeggs									
E. Hicks Loller																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS							
No			220 01 8561			Betty B. Loller			Worton, Md. 21678							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos						
Metastatic Adenocarcinoma - Colon																
DUE TO, OR AS A CONSEQUENCE OF (b)																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) End Stage Renal Failure treated by dialysis																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (the hospital) attended the deceased from saw the deceased at _____ 9/18 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death.			22b. DATE SIGNED 9/19/86			22c. DATE SIGNED 9/19/86										
22d. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22e. NAME OF PHYSICIAN (TYPE OR PRINT)			22f. ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 9/22/1986			23c. NAME OF CEMETERY OR CREMATORIUM Chester Cemetery			23d. LOCATION CITY OR TOWN Chestertown, Md.			COUNTY		STATE		
24. FUNERAL DIRECTOR NAME Willis Wells			ADDRESS Chestertown, MD			25. DATE REC'D. BY REGISTRAR SEP 25 1986			26. REGISTRAR'S SIGNATURE John S. Johnson, Jr.							

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1818 90 932

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00-19843
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed while 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or contacted.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 26 420										
												REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR										
Charles H. Fong						9/23/86						10:42A M										
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR										
Male			White			5 1 01			86			MONTHS DAYS		IF UNDER 24 HRS								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.										
Maryland			U.S.						Talbot													
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY													
Easton			Memorial Hospital			Chef			Restaurant													
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																						
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE										
Md.			Dorchester			Hurlock			YES <input type="checkbox"/> NO <input type="checkbox"/>			Rt. 1, Box 170 21643										
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST													
Henry			Long		Annie				Greene													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
No			213-05-6246			Ms. Martha Long			58 Pleasant St. Easton, Md.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)																						
Pulmonary Parker																						
DUE TO, OR AS A CONSEQUENCE OF (b) Emphysema																						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																						
DUE TO, OR AS A CONSEQUENCE OF (c)																						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE									
22a. I certify that (I) (this hospital) attended the deceased from 9/23/86 to 9/23/86, that (I) (we) last saw the deceased alive on 9/23/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.																						
22b. SIGNATURE Gary Sprouse												DEGREE										
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Gary Sprouse, M.D.												ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal												23b. DATE 9-25-86			23c. NAME OF CEMETERY OR CREMATORIAL Balto., Md.			23d. LOCATION CITY OR TOWN			COUNTY	STATE
24. FUNERAL DIRECTOR NAME Anatomy Board												ADDRESS			OCT 03 1986			REG'D BY [Signature]				
																		REG'D BY [Signature]				

E 18 <1-00

To date

and amount due \$28.00 100.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETAIN PAGES 3, 4, AND 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 3 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 21201 BALTIMORE, MARYLAND.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												6 26921			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI. DEATH MATED			MONTH	DAY	YEAR	2b. HOUR			
Mary Stevens McHarry						<input checked="" type="checkbox"/> 9-24 1986			0091						
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS AND MONTHS) YRS.	7. IF UNDER 1 YR MONTHS DAYS	8. IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR			
F	W	11/20/07	78			9-24 1986			9-24	1986	M				
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH						
ILL			USA			<input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED			TALBOT						
11. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS SOCIAL SERVICES						
EASTON			MEMORIAL			CASE WORKER									
13a. STATE MD			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS DEEP SHORE RD						
14. FATHER'S NAME BERT LOUIS STEVENS			15. MOTHER'S MAIDEN NAME REBA LENORE MAHAN												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) NO			16b. SOCIAL SECURITY NO. 328-09-0049			17. INFORMANT SUSAN HOOVER, 132 POCHN PL, HAMPTON, VA			ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 888												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) CARDIAC FAILURE DUE TO, OR AS A CONSEQUENCE OF { (b) CARDIAC ARRHYTHMIA DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSIVE CVD = PREV. ARRHYTHMIA 4 YEARS												20 MIN			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: FRACTURE (R) HIP AND (R) WRIST															
19a. DATE OF OPERATION 9-24-86			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? FRACTURED HIP (R)			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 9-23 1986			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) FELL AT HOME									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME			21f. LOCATION RT 2 BOX 10B DEEPSHORE, DEPTON CAROLINE MD									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>R.C. Thompson</i> M.D. TITLE (SPECIFY) EXAMINER'S NAME (TYPE OR PRINT) R.C. THOMPSON MD															
23a. BURIAL, CREMATION, REMOVAL (TYPE) BURIAL 9-29-86												23b. DATE 9-29-86	23c. NAME OF CEMETERY OR CREMATORIAL MAPLE WOOD	23d. LOCATION RANTOUL	23e. COUNTY ILLINOIS
24. FUNERAL DIRECTOR Moorle Funeral Home EASTON, MD												25a. DATE REC'D. BY REGISTRAR OCT 08 1986	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		
25c. DHMH - 17 (VR A15 ME (5))															

10008-00

Smith TA 1117 CAP

Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be given to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 6 2 6 4 2 8					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR						
Gilbert			McQuire Mills			9 30 86			9 10 AM						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
M		W		10 23 14			71 YRS								
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD. Talbot					
MARYLAND		U.S.A.													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			MARYLAND STATE ROADS COMMISSION					
Easton		Memorial Hosp. Easton													
13a. STATE MARYLAND		13b. COUNTY TALBOT		13c. CITY OR TOWN McDaniel			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 21647					
14. FATHER'S NAME FIRST JAMES R. MILLS		MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MARY KELLY			MIDDLE			LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-20-4427		17. INFORMANT ROBERT E. MILLS			ADDRESS 8506 WESTLINE DR. 79904 EL PASO, TEXAS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) respiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) wrenching pain Ca DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY [AT HOME, STREET, FACTORY, OFFICE, FARM ETC.]			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 9-27, 1986, to 9-20, 1986, that (II) (we) last saw the deceased alive on 9-20, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (II) (we) did not view the body after death.															
22b. SIGNATURE <i>DR. B. Sanchez</i>		22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 9-20-86							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) R.B. Sanchez		22f. ADDRESS 722 Commerce Dr. Easton													
23a. BURIAL, CREMATION, REMOVAL [SPECIFY] BURIAL		23b. DATE OCT. 3, 1986		23c. NAME OF CEMETERY OR CREMATORIAL ST. PAULS CEMETERY			23d. LOCATION VIENNA, DORCHESTER, MARYLAND								
24. FUNERAL DIRECTOR NAME Harrison E. Leonard		ADDRESS St. Michaels, Md 21663			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE John L. Johnson, Jr.										
DHMH - 16 60M 7/84 (VRA 15, 4)															

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00-18389

07/84
25M

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. RETAIN PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6 26429

REG. NO.

1- FOR STATE REGISTRAR		2a DATE KNOWN OF DEATH ESTI- MATED										2b. PLACE MONTH DAY YEAR					
		1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		<input checked="" type="checkbox"/> 9 2 1986		EL MARYLAND				
		Sr. M Loyola							MOXEY								
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. MONTH DAY YEAR			
female		white		12 1 10		75 yrs.		MONTH DAYS		HOURS MIN.		9-2-1986		10pm			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> X		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		USA														Talbot	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Easton		Memorial Hospital										Nun/Teacher		Church			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> X		13e. STREET ADDRESS									
Maryland		Caroline		Ridgely				St. Gertrude's Priory 21660									
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST							
Ignatius				Moxey		Mary				Kral							
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) IF YES, GIVE WAR OR DATES		17. SOCIAL SECURITY NO.										17. INFORMANT		ADDRESS			
no		215-62-0581										St. Gertrude's Priory		Ridgely, MD			
18. CAUSE OF DEATH (Enter only one cause per line for each part 1 or 2) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> X											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>R. McCall</i>														Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			
EXAMINER'S NAME (TYPE OR PRINT)		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS										TITLE (SPECIFY) M.D. <i>R. McCall</i> MEDICAL EXAMINER					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY#)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE							
burial		9-6-86		St. Gertrude's Cem.		Ridgely		CA		MD							
24. FUNERAL DIRECTOR NAME		ADDRESS										25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John E. Boulais		Greensboro, MD										SEP 11 1986		Julia Sandidor-Randress			

00-18382



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FULTHER DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use in the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene either in burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18, there may every, or other traumatic event, if medical requirements must be met before the death certificate can be issued.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86	26	430			
										REG. NO.					
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR	
			Laura E Nichols						9		26	86		355 P.M.	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
female			Negro			MONTH DAY YEAR			75			MONTHS DAYS		HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland			USA						Talbot County						
11. CITY OR TOWN OF DEATH			12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. INSIDE CITY LIMITS?			13c. STREET ADDRESS / ZIP CODE			
Easton			EASTON Memorial			Maryland			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Holsinger Lane 21660			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
James			Annie Henry			no			219-07-7382			Margaret Peterson Ridgely, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Bilateral lower lobe pneumonia										34 days					
DUE TO, OR AS A CONSEQUENCE OF (b)										C respiratory failure					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										massive intra cerebral hemorrhage 6 days					
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
-			-			-			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 6/20/86 to 6/26/86, that (I) (we) last saw the deceased alive on 6/20/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.															
22b. SIGNATURE										22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
Albert T. Dawkins Jr.										22d. DATE SIGNED 9/28/86					
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS			22g. LOCATION CITY OR TOWN			22h. DATE REC'D. BY REGISTRAR'S SIGNATURE OCT 06 1986						
Albert T. Dawkins Jr.			EASTON, MD 21601			Ridgely			CA MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY STATE			
Burial			10-1-86			Henry Cemetery									
24. FUNERAL DIRECTOR NAME										25. DATE REC'D. BY REGISTRAR'S SIGNATURE OCT 06 1986					
Boulais Funeral Home Greensboro, Md.															

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it may be filed within 72 hours after death.
 Should be delivered by us as the Bureau of Vital Statistics, or by mail, to the State Department of Health and Mental Hygiene, given to Bureau, elimination, or removal
 IMPORTANT: If Name 2 is omitted, see Rule 18, showing how to do so.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										862643				
										REG. NO.				
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR				
1 DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		Aug. 30, 1986		4:00 P.M.			
MAX							QVAE SCHNING							
3 SEX			4 RACE			5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)					
Male			Cau.			6-16-09			77					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.					
Germany			U.S.A.											
10 CITY OR TOWN OF DEATH Elston			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civil Engineer			12b KIND OF BUSINESS OR INDUSTRY Engineering					
13a STATE Md.			13b COUNTY Caroline			13c CITY OR TOWN Goldsboro			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS / ZIP CODE Jarrell Road 21636		
14 FATHER'S NAME Unknown			15. MOTHER'S MAIDEN NAME Unknown											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) no 121-30-0547			17. INFORMANT Lorene Regnier			ADDRESS Brentwood, N.Y.					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>HEPATORENAL FAILURE</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCITES / CIRRHOSIS</u>												unKnown		
DUE TO, OR AS A CONSEQUENCE OF (c) _____														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>ESOPHAGEAL VARICES - BLEEDING, HTN Hypertension,</u>														
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from <u>8/19/86</u> , to <u>8/30/86</u> , that (I) (we) last saw the deceased on <u>8/29/86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) did not view the body after death.														
22b SIGNATURE M. Campagnolo, M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED 8-30-86					
22d PHYSICIAN'S NAME (TYPE OR PRINT) M. CAMPAGNOLO, MD			22e ADDRESS P.O. Box 660 DENTON, MD 21629											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b DATE 8-30-86			23c NAME OF CEMETERY OR CREMATORIAL Delmarva Crematory			23d LOCATION CITY OR TOWN Lewes			COUNTY STATE Sussex Del.		
24. FUNERAL DIRECTOR NAME John E. Boulais Greensboro			ADDRESS			25a. DATE REC'D. BY REGISTRAR SEP 08 1986			25b. REGISTRAR'S SIGNATURE Julia Sciamone					

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

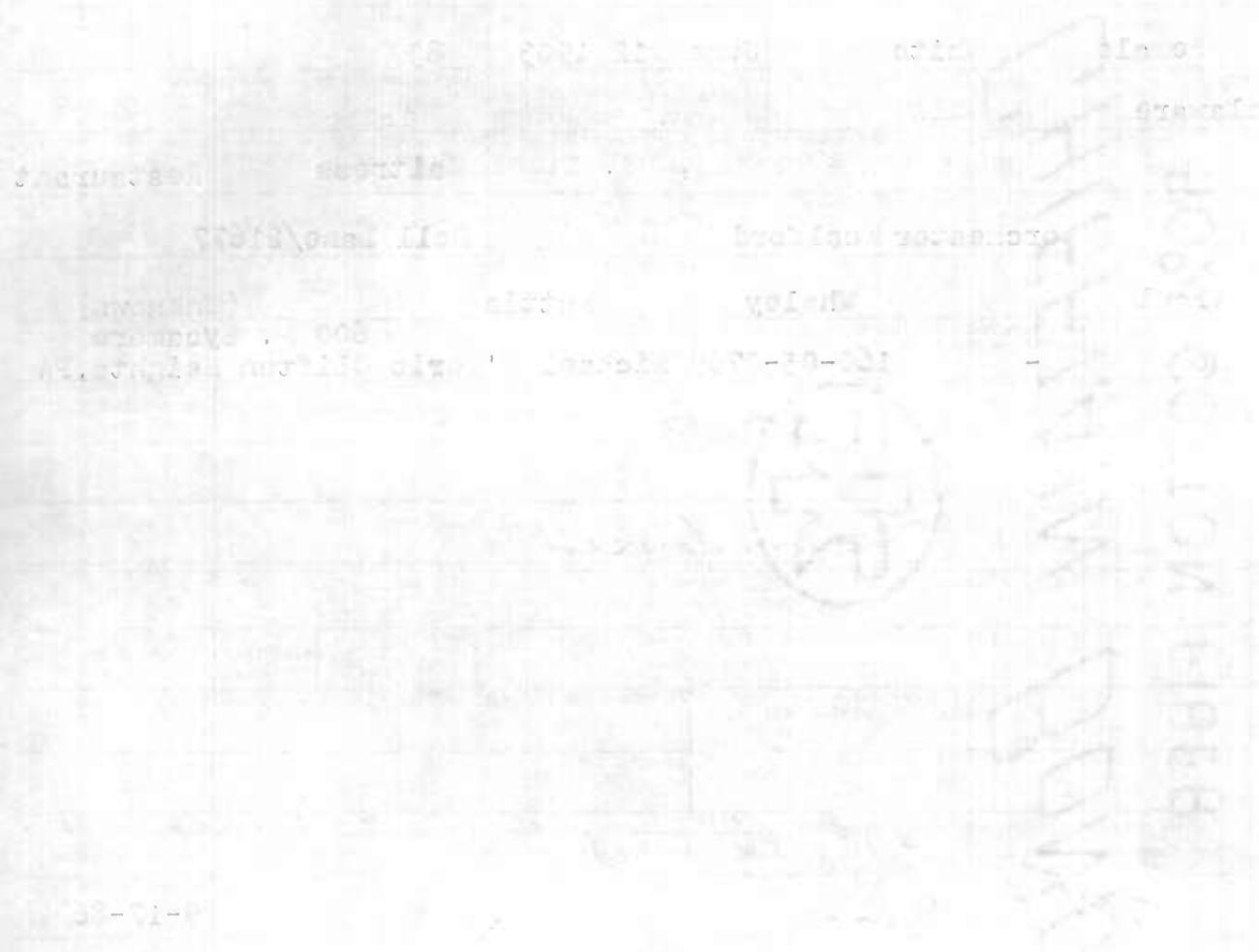
TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8626932				
										REG. NO.				
1 - STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	9/17/86							12:15AM	
Gladys Wuest Rose													M	
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS DAYS		
Female			White		June 12 1903			83				IF UNDER 24 HRS MONTHS DAYS		
YRS												HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Talbot MD						
10 CITY OR TOWN OF DEATH Easton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian - Easton, Md. 21601					12a USUAL OCCUPATION Waitress				12b KIND OF BUSINESS OR INDUSTRY Restaurant		
13a STATE MD			13b. COUNTY Dorchester		13c. CITY OR TOWN Woolford			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE Bell Lane/21677		
14 FATHER'S NAME Paul			MIDDLE	LAST	15 MOTHER'S MAIDEN NAME Mattie							(Unknown)		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT			18 ADDRESS 800 N. Sycamore				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No			-		160-05-0769 Michael D'Iorio Clifton Heights, PA									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u>														
DUE TO, OR AS A CONSEQUENCE OF (b) _____														
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerosis</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a I certify that (I) (this hospital) attended the deceased from <u>9-15</u> 19 <u>80</u> to <u>9-17</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>9-10</u> 19 <u>86</u> , and that in <u>0</u> (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>P. Lietzke, D</u>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 9-17-86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Terry P. Detrich, M.D.</u>			22e. ADDRESS <u>1405 Washington St. Easton MD 21601</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-20-86			23c. NAME OF CEMETERY OR CREMATORIAL East New Market Cem			23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR SEP 29 1986			
24. FUNERAL DIRECTOR Zeller Funeral Home, East New Market, MD									25b. REGISTRAR'S SIGNATURE <u>J. L. Detrich, M.D.</u>					

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00-19219

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8626433			
						REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	MONTH DAY YEAR	2b. HOUR 7:30 A.M.	
REBA			G	SHIRING		SEPT 23 1986			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 12 1908		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7b. IF UNDER 1 YEAR MONTHS DAYS	
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penns.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT		IF UNDER 24 HRS HOURS MIN.	
10. CITY OR TOWN OF DEATH CASTON		NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CASTON MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education	
13a. STATE Penns.		13b. COUNTY Allegheny		13c. CITY OR TOWN N. Versailles		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 404 3rd Street 99999	
14. FATHER'S NAME FIRST Allen		MIDDLE		LAST Graham		15. MOTHER'S MAIDEN NAME FIRST Sarah		MIDDLE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 182 34 5143		17. INFORMANT Hubert Shiring, Jr. (son) Stevensville, Maryland		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a), Generalized debility APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Breast cancer, widely metastatic									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from SEP 22 1986, to SEP 23 1986, that (I) (we) last saw the deceased alive on above (I) (we) (did) (did) not view the body after death.									
22b. SIGNATURE Malloy		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-23-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MD Crowley		22e. ADDRESS Easton, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept 27 86		23c. NAME OF CEMETERY OR CREMATORIAL Jefferson Mem. Park		23d. LOCATION CITY OR TOWN		COUNTY STATE	
24. FUNERAL DIRECTOR Ives Pearson F.H. Arlington, Virginia 22201				25a. DATE REC'D. 26 1986		25b. REGISTRAR'S SIGNATURE			
999999 DHMH - 76 COM 7/84 (VRA 15, 4)									

11881-00

Abraham Lincoln

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be given to the funeral director. Then please remove carbon copies. Page 3 and 2 should be left in the certificate for 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified and/or

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8	6	2	6	9	3	4		
						REG. NO.								
1 - STATE REGISTRAR			1 DECEASED NAME FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
Marie-Rose J. Shroads			September 10, 1986			6:30 PM								
3. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				
Female		White		01 23 25			61			MONTHS DAYS HOURS MIN.				
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
France		U.S.A.						Talbot						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Easton		638 Lomax Street						Housewife						
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						13e. STREET ADDRESS / ZIP CODE		
13a. STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Easton								638 Lomax Street 21601		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Raoul A. Meillier			Anna Bremond											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
no			197-24-6953			William E Shroads 638 Lomax St Easton MD								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Breast Cancer</u>													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____														
DUE TO, OR AS A CONSEQUENCE OF (c) _____														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>home</u>			21f. LOCATION STREET <u>106</u> CITY OR TOWN <u>Easton</u> COUNTY <u>Maryland</u> STATE <u>MD</u>									
22a. I certify that (I) <input type="checkbox"/> (we) <input type="checkbox"/> attended the deceased from <u>9/10</u> , 19 <u>86</u> , to <u>9/10</u> , 19 <u>86</u> , that (I) <input type="checkbox"/> (we) <input type="checkbox"/> last saw the deceased alive on <u>9/10</u> , 19 <u>86</u> , and that in (my) <input type="checkbox"/> (our) <input type="checkbox"/> death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death.														
22b. SIGNATURE <u>Ludwig J. Egseder, III, M.D.</u> DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>9/11/86</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Ludwig J. Egseder, III, M.D.</u>						22e. ADDRESS <u>Rt. 3 Box 106, Easton, MD 21601</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>9/12/86</u>		23c. NAME OF CEMETERY OR CREMATORIALY <u>Sylvania Hills Mem. Pk</u>			23d. LOCATION CITY OR TOWN <u>Rochester</u> COUNTY <u>Beaver</u> STATE <u>PA</u>							
24. FUNERAL DIRECTOR NAME <u>Newnam Funeral Home</u> ADDRESS <u>Easton, Maryland</u>						25a. DATE REC'D. BY REGISTRAR <u>SEP 16 1986</u> 25b. REGISTRAR'S SIGNATURE <u>Julia Egseder-Penske</u>								

08181-1

D.P. WROTH NOTIFIED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 4 may be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	6	2	6	9	3	5
												REG. NO.						
1 - STATE REGISTRAR			I. DECEASED NAME FIRST MIDDLE LAST									2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			MARY E. SPARKS									8-31-86			937P M			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		2d. HOUR				
Female			White			MONTH 10 DAY 9 YEAR 13			72			MONTHS DAYS		IF UNDER 24 HRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> X WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Maryland			USA						Talbot									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
EASTON			MEMORIAL HOSPITAL									homemaker			home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13e. STREET ADDRESS / ZIP CODE						
13a. STATE Maryland			13b. COUNTY Caroline			13c. CITY OR TOWN Henderson			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> X			State Rt. 313 21640						
14. FATHER'S NAME FIRST Edward			MIDDLE Sparks			LAST			15. MOTHER'S MAIDEN NAME FIRST Annie			M. LAST Anderson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS									
no			218-30-2077			Katherine Potter			Marydel, MD									
18. CAUSE OF DEATH (Enter only one cause per line for item 1b, and c) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												DUE TO, OR AS A CONSEQUENCE OF (b) atherosclerosis						
												DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 8-28-86 to 8-31-86, that (we) last saw the deceased on 8-31-86, and that in (my) our opinion death occurred on the date and hour and from the causes stated above. We will identify the body after death.												22c. DATE SIGNED						
22b. SIGNATURE <i>Detrich P.</i>												DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS															
/ Dr. T. Detrich, M.D.			Easton, Maryland 21601															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY STATE						
burial			9-3-86			Greensboro Cemetery			Greensboro			CA MD						
24. FUNERAL DIRECTOR NAME <i>John E. Bourne</i> ADDRESS <i>Greensboro</i>												25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
												SEP 08 1986		<i>John E. Bourne</i>				
DHMH - 16 60M 7/84 (VRA 15, 4)																		

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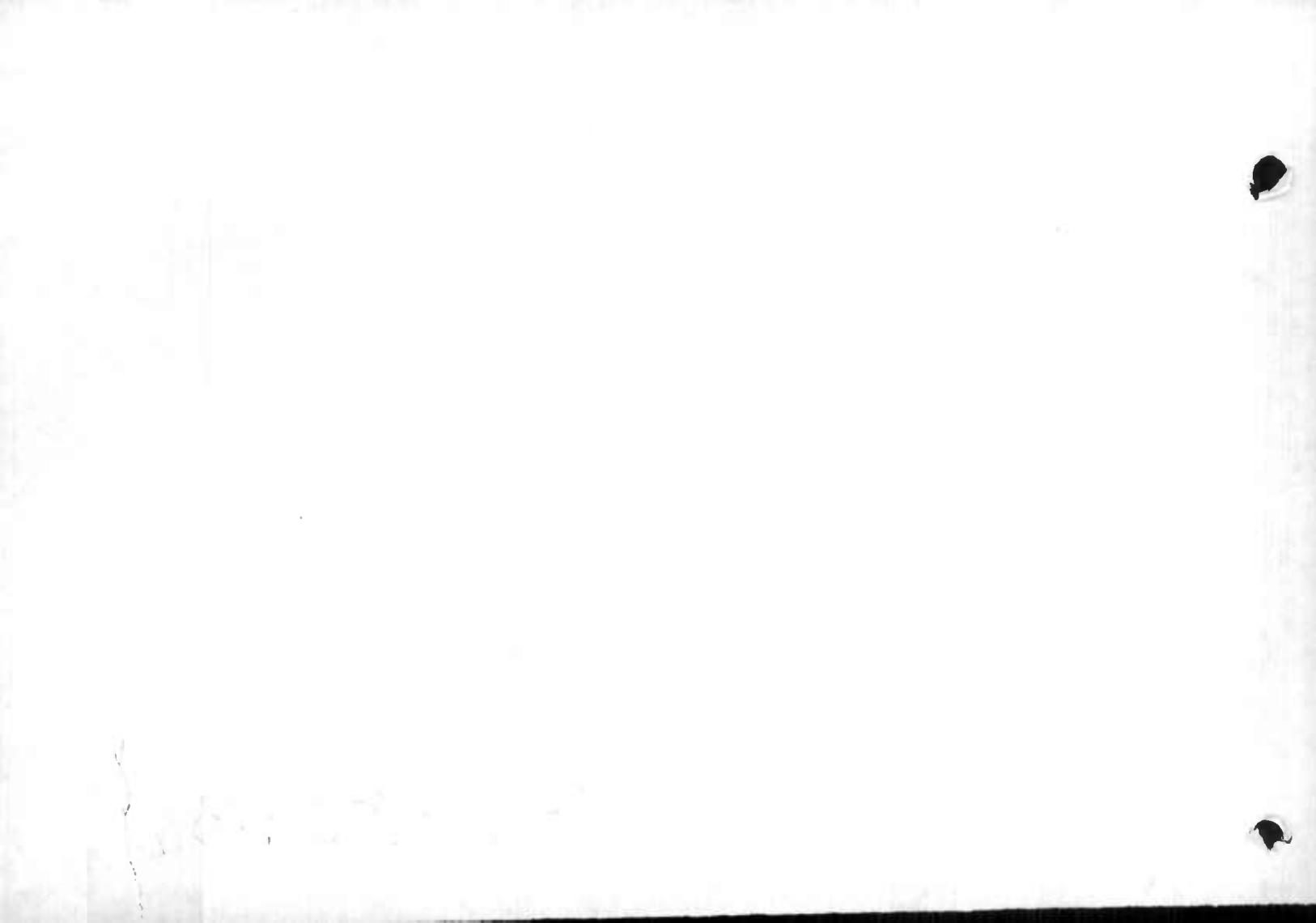
admiral school
independent
island

to Dabbs

Goodrich Island

VOID

CERTIFICATE #86-26936



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be sent to you within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use at the burial/memorial service. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8626931			
												REG. NO.			
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR			
1 - DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			9	18	86	628
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Male			White			08 04 08			78 YRS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland			U.S.A.						TALBOT						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
EASTON			MEMORIAL HOSPITAL									Printer			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
Maryland			Talbot		Easton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			501 Dutchman's Lane 21601					
14. FATHER'S NAME: FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST												
Howard E. Tarbutton			Mary Virginia Slaughter												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
no			212-09-5582			Daniel Tarbutton 6113 Calwood Way Rockville			MD 20852						
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) A. S. H. D.												16 day			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												22			
DUE TO, OR AS A CONSEQUENCE OF (c)												56 yrs			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from AUG 19 64 to 18 SEP 19 86, that (we) lost saw the deceased alive on 17 SEP 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.															
22b. SIGNATURE Stephen P. Carney, M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9-18-86						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M.D.			22e. ADDRESS Dutchman's Lane Easton MD 21601												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/20/86			23c. NAME OF CEMETERY OR CREMATORIUM Spring Hill Cemetery			23d. LOCATION CITY OR TOWN Easton			COUNTY Talbot		STATE MD	
24. FUNERAL DIRECTOR NAME Newnam Funeral Home			ADDRESS Easton MD			25a. DATE REC'D. BY REGISTRAR SEP 23 1986			25b. REGISTRAR'S SIGNATURE Frieder						

accsai - 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-trait permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

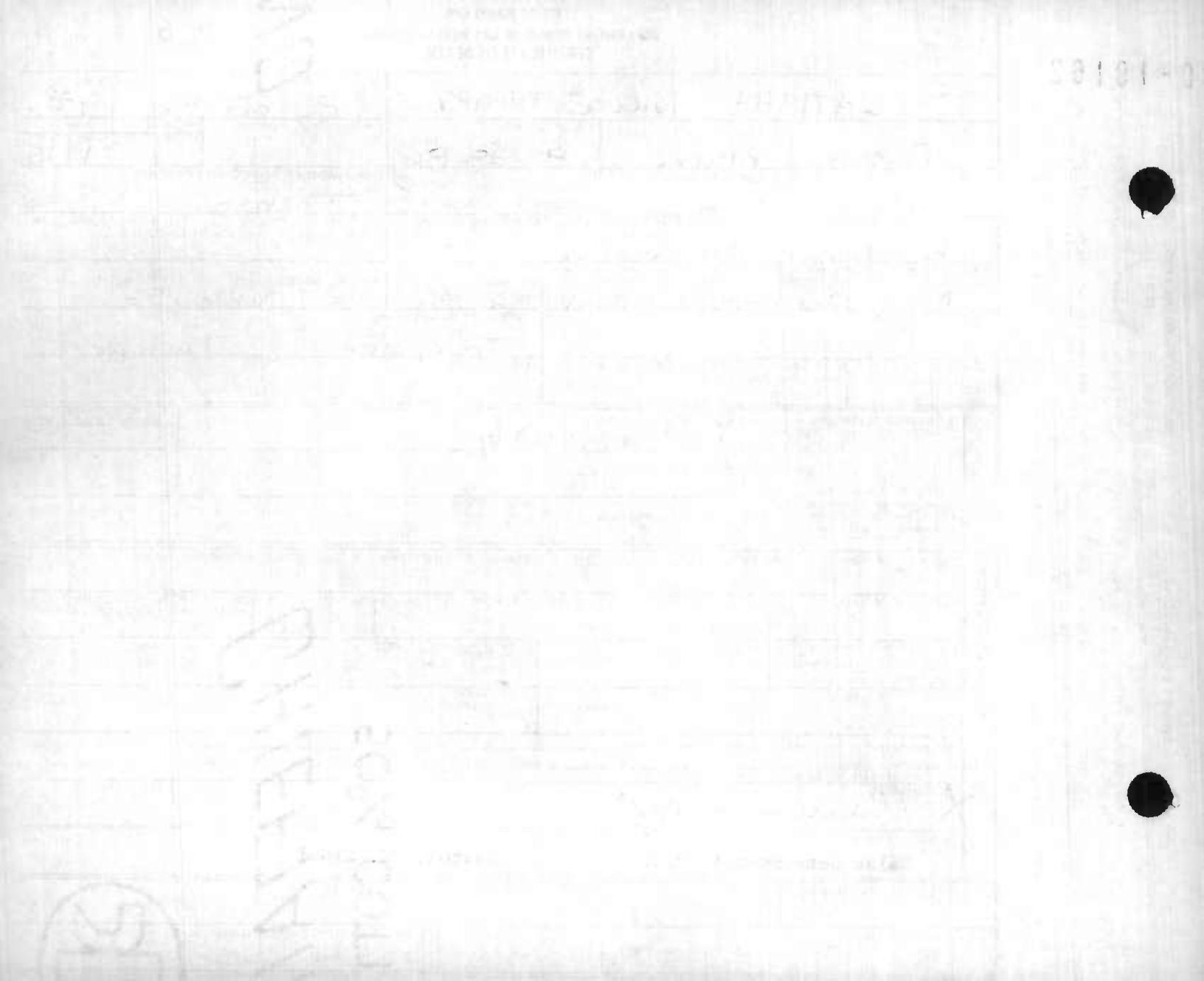
1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 26 + 38

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
LATISHA NICOLE THOMPSON						8 - 28 - 86				9:30 M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Female		Black		8 28 86		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		YRS.		1 15	
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Md		USA				Talbot					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Easton		Memorial									
13a. STATE Md		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 507 Oakley St		214013	
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME Josephine		ADDRESS		LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <input checked="" type="checkbox"/> IMMORTALITY		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) _____		(c) _____		DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>X Malak</i>		70		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		Malak Derakhshani, M.D.		22e. ADDRESS Easton, Md. 21601							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>SEP 25 1980 Julia Davidson-Randall</i>					

20101-0



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 3 and 4 may be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or if Item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

MEDICAL CERTIFICATION

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 9 3 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
EDWARD LEE WARNER						September 10, 1986				11:30AM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		White		MONTH DAY YEAR 08 22 09			77 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Maryland		U.S.A.					Talbot					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Easton		621 South Street			Owner/Operator			Service Station				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13b. STREET ADDRESS / ZIP CODE						
Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		21601						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			ADDRESS				
Joseph		J.	Warner		Laura			Berridge				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No		216-03-7449			Ethel L. Warner 621 South St Easton MD 21601			15 yrs				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rheumatoid arthritis</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) _____												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____												
DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
19b. YES <input type="checkbox"/> NO <input type="checkbox"/>							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>9-9-1986</u> , to <u>12-27-1986</u> , to <u>9-10-1986</u> . that (I) (we) last saw the deceased alive on <u>9-9-1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Stephen P. Carney</u>		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9-11-86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M.D.		22e. ADDRESS Dutchman's Lane Easton MD 21601										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/12/86		23c. NAME OF CEMETERY OR CREMATORIAL Spring Hill Cemetery			23d. LOCATION CITY OR TOWN Easton		23e. COUNTY Talbot			
24. FUNERAL DIRECTOR NAME Newnam Funeral Home		ADDRESS Easton MD			25a. DATE REC'D. BY REGISTRAR SEP 16 1986			25b. REGISTRAR'S SIGNATURE <u>John J. Newnam</u>				
DHMH - 16 60M 7/84 (VRA 15, 4)												

81181-1

098-2193-1

10
0-18693
after death. Page 4 may be
repeated.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the burial permit. Then affix stamp or signature. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or items 18 through any injury, or other traumatic event, the medical certificate must be signed by the attending physician.

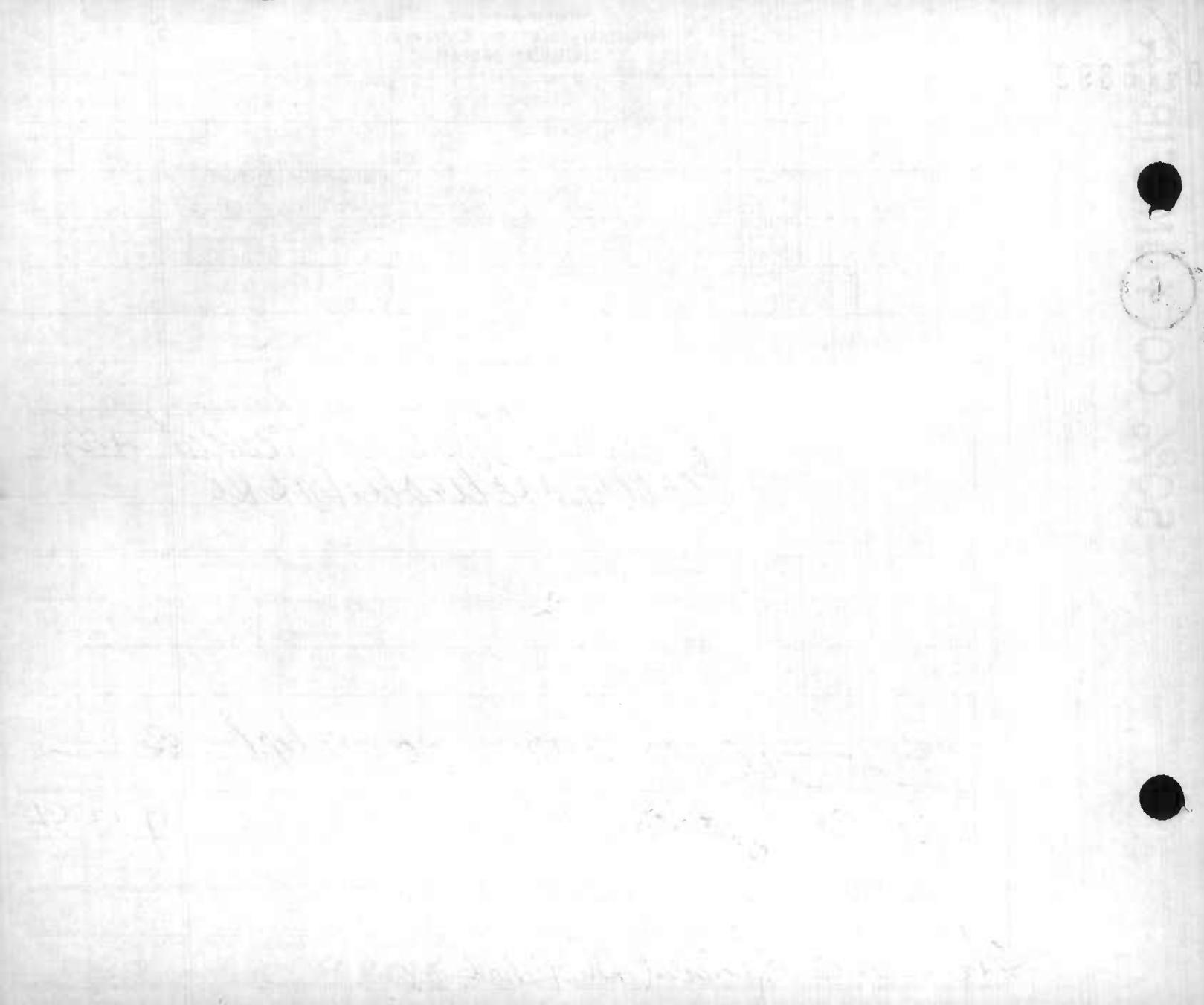
MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 26440

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Lucille				VIRGINIA	Wharton	Sept. 12, 1986				6:53 p.m.
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR	
F		II 2	MONTH	DAY	YEAR	86	MONTHS	YEARS	MONTHS	YEARS
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			MD. FIRE UNDERWRITERS RATING	
MARYLAND		U.S.A.			Talbot County			BUREAU		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Easton		Mereidian Nursing-The Pines			MD. FIRE UNDERWRITERS RATING			ADDRESS		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		
MARYLAND		TALBOT		ST. MICHAELS		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. CHEW AVE 21663		
14. FATHER'S NAME FIRST		MIDDLE	LAST			15. MOTHER'S MARRIED NAME FIRST		MIDDLE		
THOMAS FITZPATRICK						IDA JEAN SINCLAIR		LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS		
NO		037-01-1051A			RICHARD H. WHARTON			871 AMES AVE. 94303 PALO ALTO, CALIFORNIA		
18. CAUSE OF DEATH (Enter only one cause per line. Part 1 or 2, and 18a) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		18b. DUE TO, OR AS A CONSEQUENCE OF (b)			18c. DUE TO, OR AS A CONSEQUENCE OF (c)			18d. PRELIMINARY INTERVIEW BY FUNERAL DIRECTOR AND ATTENDING PHYSICIAN		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (he/she) attended the deceased from July 17, 1986, to Sept. 17, 1986, and that (I) (he/she) last saw the deceased alive on Sept. 17, 1986, and that in (my) (his/her) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (did not) view the body after death.										
22b. SIGNATURE		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		DATE SIGNED			
R. LANE WROTH M.D.		ST. MICHAELS, MARYLAND 21663					9-13-86			
23a. BURIAL, CREMATION, REMOVAL OF BODY		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		23e. COUNTY STATE		
BURIAL		SEPT. 17, 1986		OLIVET CEMETERY		ST. MICHAELS, TALBOT		MARYLAND		
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Harmon E. Leonard, St. Michaels					Sept. 19, 1986		John Davidson-Bender			



00-19327

1-
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 6 4 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST VIVA	MIDDLE Ross	LAST Willey	2d. DATE OF DEATH MONTH September	DAY 23	YEAR 1986	2b. HOUR 2 4 PM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH 10			DAY 29	YEAR 06	6. AGE (IN YEARS LAST BIRTHDAY) MONTHS 79	YRS 0	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Talbot
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse's Aid			12b. KIND OF BUSINESS OR INDUSTRY Hospital						
13a. STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Tilghman			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Chicken Point Road 21671			
14. FATHER'S NAME FIRST Thomas		MIDDLE J.		LAST Ross			15. MOTHER'S MAIDEN NAME FIRST Sarah			MIDDLE E.	LAST Harrison		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-10-9756		17. INFORMANT Mary Larrimore Rt 1 Box EV3 Preston MD 21655									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) AS CVD DUE TO, OR AS A CONSEQUENCE OF (c) SEPSIS												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Parkinson's Disease - Severe ; DIABETES MELLITUS													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2) 9/21 1986								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 9/23 1986			21f. LOCATION STREET 9/23			CITY OR TOWN Easton	COUNTY Talbot	STATE MD			
22a. I certify that (I) this physician attended the deceased from 9/21 1986 to 9/23 1986 , that (my) (we) last saw the deceased 9/23 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) did not view the body after death.													
22b. SIGNATURE William J. Bahfield, M.D.		22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 505 Dutchman's Lane Easton MD 21601					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William J. Bahfield, M.D.		22e. ADDRESS 505 Dutchman's Lane Easton MD 21601											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/25/86		23c. NAME OF CEMETERY OR CREMATORIUM St John's Meth. Cemet.			23d. LOCATION CITY OR TOWN Tilghman			COUNTY Talbot	STATE MD		
24. FUNERAL DIRECTOR NAME Newnam Funeral Home		ADDRESS Easton MD 21601			25a. DATE REC'D. BY REGISTRAR SEP 26 1986			25b. REGISTRAR'S SIGNATURE Newnam Funeral Home					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ESSEB 1-00

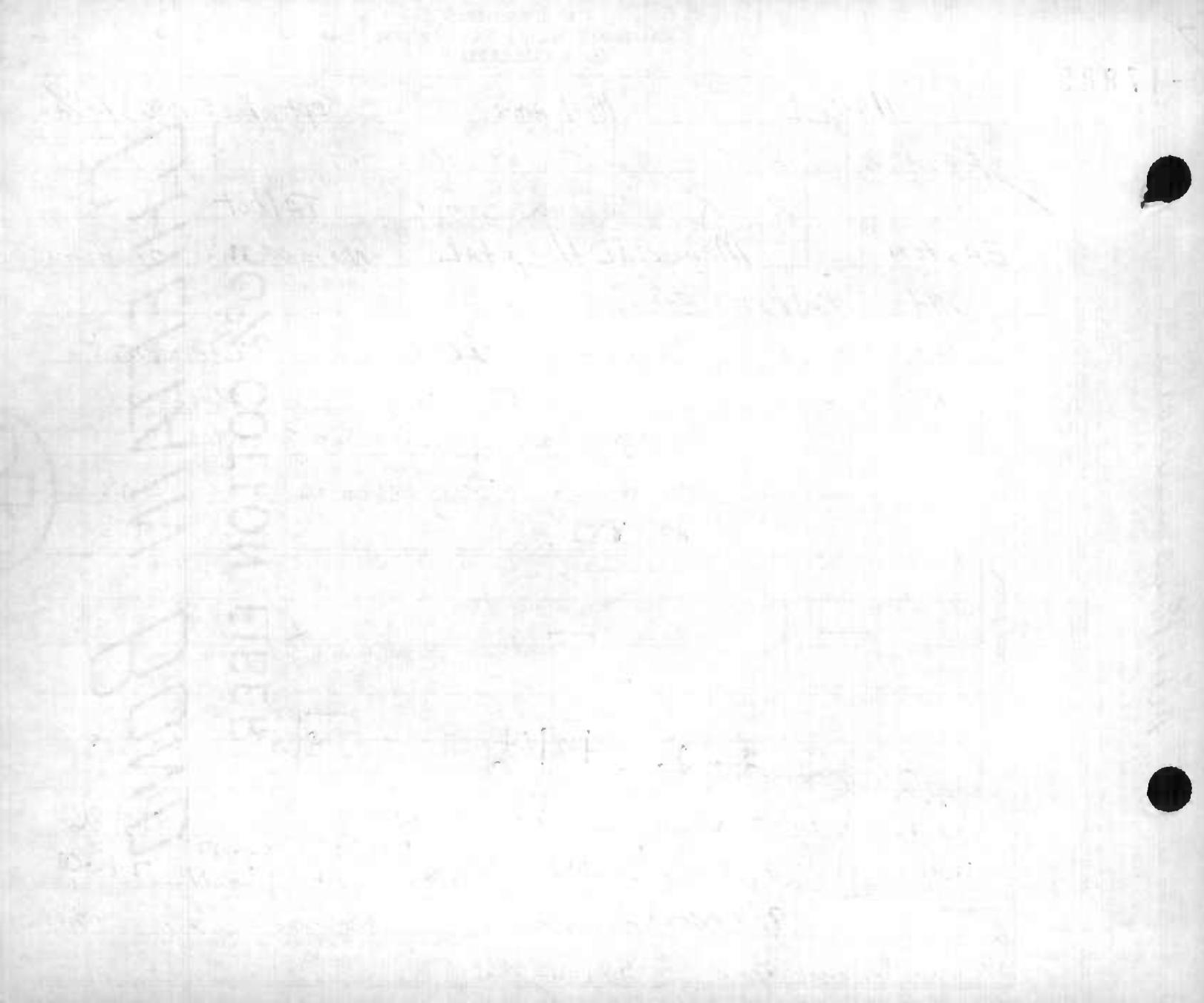
Albert T. DAWKINS, Sr.

TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and countersigned in by the funeral director, page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and countersigned in by the funeral director, page 4 may be returned by the hospital or attending physician. This will release removal of embalming permit. Then release remove embalming papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be consulted at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 2 6 7 4 2		
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR 12 ^{1/2} AM	
<i>Hazel Williams</i>					<i>Williams</i>	<i>September 5 1986</i>						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH 7 DAY 30 YEAR 17			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
<i>Female</i>		<i>BLK</i>					<i>69</i>					
7. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i>		10. KIND OF BUSINESS OR INDUSTRY <i>Nurse Aid</i>			
11. CITY OR TOWN OF DEATH <i>EASTON</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN A FACILITY, GIVE STREET ADDRESS) <i>Memorial Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Nurse Aid</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>						
13a. STATE <i>MD</i>		13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>EASTON</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>21601</i>				
14. FATHER'S NAME <i>William H. Camper</i>		15. MOTHER'S MAIDEN NAME <i>Doris L. Dennis</i>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Dorothy Wilson</i>		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>ventricular fibrillation & asystole</i>												
DUE TO, OR AS A CONSEQUENCE OF (b) <i>coronary artery disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												
DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASCD</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION <i>—</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>— 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <i>—</i>							
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>—</i>		21f. LOCATION STREET <i>—</i> CITY OR TOWN <i>915</i> COUNTY <i>80</i> STATE <i>MD</i>							
22a. I certify that (1) (this hospital) attended the deceased from <i>8/4/86</i> to <i>9/12/86</i> , 19 <i>—</i> , to <i>9/15/86</i> , 19 <i>—</i> , that (1) (we) last saw the deceased alive on <i>8/4/86</i> , 19 <i>—</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Albert T. Dawkins Jr. MD</i>			22c. DEGREE ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <i>9/15/86</i>							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Albert T. Dawkins Jr. MD</i>			22f. ADDRESS <i>Route 3 Box 127 Session, Maryland 21601</i>									
23a. BURIAL, CREMATION, REMOVAL <i>—</i>		23b. DATE <i>9/19/86</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Richardson</i>		23d. LOCATION CITY OR TOWN <i>EASTON</i> COUNTY <i>MD</i> STATE <i>MD</i>						
24. FUNERAL DIRECTOR NAME <i>Stewart Funeral Home</i>		ADDRESS <i>Salisbury Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>SEP 15 1986</i>		25b. REGISTRAR'S SIGNATURE						



00-17535

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6 26443

REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANYDAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, 3 AND 5 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM M-1. PAGES 1, 2, 3, 5, 6, 7A, 7B, 7C, 7D, 7E, 7F, 7G, 7H, 7I, 7J, 7K, 7L, 7M, 7N, 7O, 7P, 7Q, 7R, 7S, 7T, 7U, 7V, 7W, 7X, 7Y, 7Z SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. AND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- STATE REGISTRAR		2. DECEASED NAME FIRST MIDDLE LAST												2a DATE KNOWN OF ESTI- DEATH MATED		2b HOUR					
		<i>Helen H. Williams</i>												<input checked="" type="checkbox"/> 9 5 1986		5:00 P.M.					
3 SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR					
Female		White		09 22 12			73 yrs.			MONTHS		DAYS HOURS MIN		MONTH DAY YEAR		19 M					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?												8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Maryland		U.S.A.												<i>Talbot</i>							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Easton		Memorial Hospital, S Washington St												Dietician		Nursing Home					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
Maryland		Talbot		Cordova		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RD 1 Box 234						21625							
4. FATHER'S NAME				LAST		15. MOTHER'S MAIDEN NAME															
Samuel		Francis		Harrison		Alice															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS															
no		220-09-1340		Gloria Truitt Rt 1 Box 110 Preston MD																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I DEATH WAS CAUSED BY: <i>8199</i> IMMEDIATE CAUSE (a) <i>Depressed fractures skull</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Auto Accident</i> DUE TO, OR AS A CONSEQUENCE OF (c)																					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?											20. AUTOPSY?							
														YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR AM MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)															
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			4:59 P.M. 9 5 1986			<i>Drove into Rte 309 -</i>															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE							
			<i>Rte 309 X School lane</i>			<i>NR Cordova Tal Rd</i>															
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE		<i>Louis S. Welty</i>												TITLE (SPECIFY) M.D. <i>for Sep</i>		MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)		<i>Louis S. Welty</i>												ADDRESS <i>EASTON MD</i>		DATE SIGNED <i>9-5-86</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE							
Burial			9/9/86			Woodlawn Memorial Park			Easton			Talbot		MD							
24. FUNERAL DIRECTOR NAME		ADDRESS <i>Newnam Funeral Home Easton MD</i>												25a. DATE REC'D. BY REGISTRAR <i>SEP 10 1986</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					
BP																					
DHMH - 17 (VR A15 ME (5))																					

CO-15232



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified immediately.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8626444					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
GEORGE PETER WOOD						AUG 31, 1986						9:40 AM			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS (LAST BIRTHDAY))			IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE			WHITE			DEC. 2, 1914			71			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
MARYLAND			USA						TALBOT						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (UNKNOWN SURFACE, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK OR KIND OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
EASTON			MEMORIAL HOSPITAL			FARMER			FARMING						
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS						
MD			CAROLINE			DENTON			TUCKAHOE RD. 29						
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST				
CHARLES WASHINGTON WOOD						FRANCIS MARGARET BACH									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Auto myocardial infarction</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO			214365552			MARY B. Wood, DENTON, MD.						<i>month</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b).			(b)			DUE TO, OR AS A CONSEQUENCE OF									
			(c)			DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <i>Estate dyslipidemia</i>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb 18, 1967</i> to <i>Sept 10, 1986</i> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <i>06/14/1986</i> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did not view the body after death.															
22b. SIGNATURE <i>PD</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>09/05/86</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Philip P. Feliciano</i>			22e. ADDRESS <i>Dunda, MD 21628</i>												
23a. BURIAL, CREMATION, REMOVAL <i>BURIAL</i>			23b. DATE <i>SEPT. 3, 1986</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>DENTON CEMETERY</i>			23d. LOCATION <i>DENTON, CAROLINE Q MD</i>						
24. FUNERAL DIRECTOR NAME <i>MOORE FUNERAL HOME, DENTON, MD</i>			ADDRESS <i>SEP 10, 1986</i>			25. DUE DATE FOR REGISTRATION, REGISTRAR'S SIGNATURE <i>John P. Moore</i>									

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